



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Drug Control Program
239 Causeway Street, Suite 500
Boston, MA 02114

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www.mass.gov/orgs/massachusetts-controlled-substances-registration

**Massachusetts Controlled Substance Registration (MCSR)
Advanced Practice Provider Removal Form for Supervising Physicians**

Advanced Practice Provider Removal Form Instructions

Please read the following information carefully before completing the form:

- 1. This form is only intended to allow supervising physicians to disassociate an advance practice provider (APRN, PA, or CDTM Pharmacist) from their Massachusetts Controlled Substance Registration (MCSR).**
- 2. Items with an asterisk are mandatory. We are unable to process incomplete forms.**
- 3. If you are removing more than three advanced practice providers, please photocopy page 2 and include that with your form submission.**
- 4. Attest to the content of the form by signing and dating the second page. The Drug Control Program cannot accept amended information forms without a signature.**
- 5. When complete, send the amended information form by either email, fax, or mail:**

Email: MCSR@massmail.state.ma.us

Fax: 617-753-8233

Mail:

Bureau of Health Professions Licensure
Drug Control Program, Attn: MCSR
239 Causeway Street, 5th Floor Suite 500
Boston, MA 02114

Carefully Print or Type the Following Information:

First Name*:	Last Name*:	MCSR Number*:	Massachusetts Medical License Number*:

<input type="checkbox"/> Remove an Advanced Practice Provider (NP/PA/CDTM RPh)		
Last Name*:	First Name*:	MCSR #*:

<input type="checkbox"/> Remove an Advanced Practice Provider (NP/PA/CDTM RPh)		
Last Name*:	First Name*:	MCSR #*:

<input type="checkbox"/> Remove an Advanced Practice Provider (NP/PA/CDTM RPh)		
Last Name*:	First Name*:	MCSR #*:

I hereby certify that, under pains and penalties of perjury, all of the information submitted in this form, and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this form is grounds for MCSR revocation or denial of the MCSR and may subject me to civil or criminal penalties. My signature on this MCSR form attests under penalties of perjury that, to the best of my knowledge and belief, I have complied with: state tax and child support laws M.G.L. c. 62C, section 49A); and the laws of the commonwealth of Massachusetts and all applicable rules and regulations of the Department of Public Health and the Drug Control Program.

Signature*: _____

Date*: _____